

When does benign shyness become social anxiety, a treatable disorder?

The authors pinpoint the fine line between overdiagnosis and underdiagnosis of SAD

Since the appearance of social anxiety disorder (SAD) in the DSM-III in 1980, research on its prevalence, characteristics, and treatment have grown (*Box 1, page 22*^{1,2}). In addition to the name, the definition of SAD has changed over the years; as a result, its prevalence has increased in recent cohort studies. This has led to debate over whether the experience of shyness is being over-pathologized, or whether SAD has been underdiagnosed in earlier decades. Those who argue that shyness is being over-pathologized note that it is a normal human experience that has evolutionary functions (eg, preventing engagement in harmful social relationships³). Others argue that a high degree of shyness is not beneficial in terms of evolution because it causes the individual to be shunned, so to speak, by society.⁴

Why worry about 'over-pathologizing'?

The medicalization of shyness might be a reflection of Western societal values of assertiveness and gregariousness; other societies that value modesty and reticence do not over-pathologize shyness.⁵ It is important not to assume that someone who is shy necessarily has a "pathologic" level of social anxiety, especially because some people who are shy view that condition as a positive quality, much like sensitivity and conscientiousness.⁵

The broader issue of what constitutes a mental disorder arises in this debate. A "disorder" is a socially constructed label that describes a set of symptoms occurring together and its associated behaviors, not a real entity with etiological homogeneity.⁶ Labeling emotional problems "disordered" assumes that happiness is the natural homeostatic state, and



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Determining when shyness becomes a clinically significant problem demands a delicate distinction that has treatment implications



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Box 1

What's in a name?

The name of social anxiety disorder (SAD) has changed over the years in the DSM. First referred to as *social phobia* in the DSM-III, it later was given the alternative name of *social anxiety disorder* in DSM-IV. Most recently, it has been fully changed to *social anxiety disorder (social phobia)* in DSM-5, based on the belief that “social phobia” does not reflect the impairing and pervasive nature of the disorder.¹

The generalized specifier was removed in DSM-5, perhaps because the name change is more reflective of this more severe subtype, and the specifier “performance only” was added, based on recent research suggesting that persons with performance-only fears significantly differ from those with multiple fears (see Bögels and colleagues’ review of this topic²). The performance-only form of SAD is significantly less prevalent than the generalized form, and tends to be treated with as-needed medication (eg, a beta blocker) that can be taken before entering a performance situation.

distressing emotional states are abnormal and need to be changed.⁷ A diagnostic label can help improve communication and understand maladaptive behaviors; if that label is reified, however, it can lead to assumptions that the etiology, course, and treatment response are known. Proponents of the diagnostic psychiatric nomenclature have acknowledged the dangers of over-pathologizing normal experiences of living (such as fear) by way of diagnostic labeling.⁸

Determining when shyness becomes a clinically significant problem—what we call SAD here—demands a delicate distinction that has important implications for treatment. On one hand, if shyness is over-pathologized, persons who neither desire nor need treatment might be subjected to unnecessary and costly intervention. On the other hand, if SAD is underdiagnosed, some persons will not receive treatment that might be beneficial to them.

In this article, we review the similarities and differences between shyness and SAD, and provide recommendations for determining when shyness becomes a more clinically significant problem. We also highlight the importance of this distinction as it

pertains to management, and provide suggestions for treatment approaches.

SAD: Definition, prevalence

SAD is defined as a significant fear of embarrassment or humiliation in social or performance-based situations, to a point at which the affected person often avoids these situations or endures them only with a high level of distress⁹ (Table 1, and Box 2, page 35). SAD can be distinguished from other anxiety disorders based on the source and content of the fear (ie, the source being social interaction or performance situations, and the content being a fear that one will show a behavior that will cause embarrassment). SAD also should be distinguished from autism spectrum disorders, in which persons have limited social communication capabilities and inadequate age-appropriate social relationships.

SAD is most highly comorbid with mood and anxiety disorders, with rates of at least 30% in clinical samples.¹⁰ The disorder also is highly comorbid with avoidant personality disorder—to a point at which it is argued that they are one and the same disorder.¹¹

As with other psychiatric disorders, anxiety must cause significant impairment or distress. What constitutes significant impairment or distress is subjective, and the arbitrary nature of this criterion can influence estimates of the prevalence of SAD. For example, prevalence ranges as widely as 1.9% to 20.4% when different cut-offs are used for distress ratings and the number of impaired domains.¹²

The prevalence of SAD varies from 1 epidemiological study to another (ie, the Epidemiological Catchment Area [ECA] Study and the National Comorbidity Survey [NCS])—in part, a consequence of the differing definitions of significant impairment or distress. The ECA study assessed the clinical significance of each symptom in anxiety disorders; the NCS assessed overall clinical significance of the disorder. When the clinical significance criterion was applied at the symptom level to the NCS dataset (as was done in the ECA study), 1-year prevalence decreased by

50% (from 7.4% to 3.7%).¹³ The manner in which significant impairment or distress is defined (ie, conservatively or liberally) impacts whether social anxiety symptoms are classified as disordered or non-disordered.

Shyness: Definition, prevalence

Shyness often refers to 1) anxiety, inhibition, reticence, or a combination of these findings, in social and interpersonal situations, and 2) a fear of negative evaluation by others.¹⁴ It is a normal facet of personality that combines the experience of social anxiety and inhibited behavior,¹⁵ and also has been described as a stable temperament.¹⁶ Shyness is common; in the NCS study,¹⁷ 26% of women and 19% of men characterized themselves as “very shy”; in the NCS Adolescent study,¹⁸ nearly 50% of adolescents self-identified as shy.

Persons who are shy tend to self-report greater social anxiety and embarrassment in social situations than non-shy persons do; they also might experience greater autonomic reactivity—especially blushing—in social or performance situations.¹⁵ Furthermore, shy persons are more likely to have axis I comorbidity and traits of introversion and neuroticism, compared with non-shy persons.¹⁴

Research suggests that temperament and behavioral inhibition are risk factors for mood and anxiety disorders, and appear to have a particularly strong relationship with SAD.¹⁹ A recent prospective study showed that shyness tends to increase steeply in toddlerhood, then stabilizes in childhood. Shyness in childhood—but not toddlerhood—is predictive of anxiety, depression, and poorer social skills in adolescence.²⁰

A qualitative, or just quantitative, difference?

It is clear that SAD and shyness share several features—including anxiety and embarrassment—in social interactions. This raises a question: *Are SAD and shyness distinct qualitatively, or do they represent points along a continuum, with SAD being an extreme form of shyness?*

Table 1

Summarizing DSM-5 diagnostic criteria for SAD

1. Significant anxiety occurs in interaction or performance-based situations when one fears being judged negatively by others because of their behavior (eg, saying something “foolish”), or because they may appear nervous or anxious
2. These types of situations often cause the person to feel anxious, and this anxiety should persist for >6 months
3. The anxiety is excessive compared with what would be expected given the situation or cultural context
4. The feared social situations often are avoided or, if unavoidable, are endured with a high degree of distress
5. The person experiences several negative consequences because of anxiety or avoidance (eg, inability to perform in important social, educational, or occupational roles), or is highly distressed because of his (her) anxiety
6. The anxiety is not due to substances, medical conditions, or symptoms of other mental disorders.
7. When a person has a medical condition (such as obesity), SAD can be diagnosed 1) as long as the presence of the disorder is unrelated to the medical condition, or 2) if the anxiety is greater than what would be expected given the medical condition

SAD: social anxiety disorder

Continuum hypothesis. Support for the continuum hypothesis includes evidence that SAD and shyness share several features, including autonomic arousal, deficits in social skills (eg, aversion of gaze, difficulty initiating and maintaining conversation), avoidance of social situations, and fear of negative evaluation.^{21,22} In addition, both shyness and SAD are highly heritable,²³ and mothers of shy children have a significantly higher rate of SAD than non-shy children do.²⁴ No familial or genetic studies have compared heritability and familial aggregation in shyness and SAD.

According to the continuum hypothesis, if SAD is an extreme form of shyness, all (or nearly all) persons who have a diagnosis of SAD also would be characterized as shy. However, only approximately one-half of such persons report having been

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Box 2

Presentations of normal shyness and SAD

Shyness:**She “hangs back” at social occasions**

Margaret, age 35, is a married woman who works full-time as an accountant. She describes herself as always having been a “quiet and reserved” person. She reports having a few friends as an adolescent and “sometimes” participating in group activities, although she considered herself to be more of a follower than a leader.

Margaret has 2 or 3 close friends with whom she socializes a few times a month, but spends most of her leisure time with her husband and 2 children. When meeting new people or speaking with smaller groups of people at a social gathering, she tends to “hang back” and say little, especially at the beginning of the conversation. She sometimes worries that other people may not like her, but she nonetheless makes an effort to join in on the conversation.

Margaret has received good performance reviews. She tends to keep to herself at work, but occasionally strikes up a conversation with a coworker while waiting for a meeting to begin. Although she prefers to not speak up at meetings, she will do so when necessary. Margaret describes herself as satisfied with the quality and quantity of her social relationships, and indicates that she believes that work is going well.

SAD:**He never raised his hand in school**

John, age 50, is a single man who reports significant anxiety when interacting with others socially and during public speaking—fearing that he will say something “stupid” and therefore embarrass himself. He describes experiencing this anxiety since childhood, during which time he never raised his hand in class, often skipped classes when he was required to give a speech, and had only 1 friend.

Because of his anxiety about speaking in class, John never attended college after he received his high school degree. He has held various jobs at fast-food restaurants, but is unemployed now.

Although John considers himself a hard worker, he experienced difficulty in previous jobs when having to interact with customers or his supervisor. He wants to re-enter the workforce, but is highly nervous about having to apply and interview for jobs.

John has never been married, and dated on only a few occasions. He would like to have a romantic relationship at some point, but fears rejection. He continues to have only 1 friend, with whom he socializes once a month.

shy in childhood.¹⁷ Less than one-quarter of shy persons meet criteria for SAD.^{14,18} Because many persons who are shy do not meet criteria for SAD, and many who have SAD were not considered shy earlier in life, it has been suggested that this supports a qualitative distinction.

Qualitative distinctiveness. Despite having similarities, several features distinguish the experience of SAD from that of shyness. Compared with shyness, a SAD diagnosis is associated with:

- greater comorbidity
- greater severity of avoidance and impairment
- poorer quality of life.^{18,21,25}

Studies that compared SAD, shyness without SAD, and non-shyness have shown that the shyness without SAD group more closely resembles the non-shy group than the SAD group—particularly with regard to impairment, presence of substance use, and other behavioral problems.^{18,25}

Given the evidence, experts have concluded that shyness and a SAD diagnosis are overlapping yet different constructs that encapsulate qualitative *and* quantitative differences.²⁵ There is a spectrum of shyness that ranges from a normative level to a higher level that overlaps the experience of SAD, but the 2 states represent different constructs.²⁵

Guidance for making an assessment.

Because of similarities in anxiety, embarrassment, and other symptoms in social situations, the best way to determine whether shyness crosses the line into a clinically significant problem is to assess the severity of the anxiety and associated degree of impairment and distress. More severe anxiety paired with distress about having anxiety and significant impairment in multiple areas of functioning might indicate more problematic social anxiety—a diagnosis of SAD—not just “normal” shyness.

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To determine whether shyness crosses into a clinically significant problem, assess anxiety severity and degree of impairment and distress



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One disadvantage to relying on a rating scale alone is the narrow focus on symptoms

Table 2

Sample questions for determining clinical significance of symptoms

Has this anxiety interfered with your ability to initiate or maintain friendships? If so, how?
In what ways has this anxiety interfered with your ability to work or go to school?
Has this anxiety prevented you from having romantic relationships?
How satisfied are you with your social life?
Are you unable to hold a job or apply for jobs because of this anxiety?
How distressed or upset are you about having this anxiety?
How would your life be different if you were not bothered by this anxiety?
Did this anxiety affect your grades when you were in school?
Does this anxiety prevent you from being the type of employee you would like to be?
Has this anxiety affected the quality of relationships you would like to have with family?
In what ways has this anxiety affected your role as a parent? ^a

^aOr as a sibling, friend, partner, coworker, etc.

It is important to take into account the environmental and cultural context of a patient's distress and impairment because these features might fall within a normal range, given immediate circumstances (such as speaking in front of a large audience when one is not normally called on to do so, to a degree that does not interfere with general social functioning⁶).

What is considered a normative range depends on the developmental stage:

- Among children, a greater level of shyness might be considered more normative when it manifests during developmental stages in which separation anxiety appears.
- Among adolescents, a greater level of shyness might be considered normative especially during early adolescence (when social relationships become more important), and during times of transition (ie, entering high school).
- In adulthood, a greater level of normative shyness or social anxiety might

be present during a major life change (eg, beginning to date again after the loss of a lengthy marriage or romantic relationship).

Assessment tools

Assessment tools can help you differentiate normal shyness from SAD. Several empirically-validated rating scales exist, including clinician-rated and self-report scales.

Liebowitz Social Anxiety Scale²⁶ rates the severity of fear and avoidance in a variety of social interaction and performance-based situations. However, it was developed primarily as a clinician-rated scale and might be more burdensome to complete in practice. In addition, it does not provide cut-offs to indicate when more clinically significant anxiety might be likely.

Clinically Useful Social Anxiety Disorder Outcome Scale (CUSADOS)²⁷ and **Mini-Social Phobia Inventory (Mini-SPIN)**²⁸ are brief self-report scales that provide cut-offs to suggest further assessment is warranted. A cut-off score of 16 on the CUSADOS suggests the presence of SAD with 73% diagnostic efficiency.

One disadvantage to relying on a rating scale alone is the narrow focus on symptoms. Given that shyness and SAD share similar symptoms, it is necessary to assess the degree of impairment related to these symptoms to determine whether the problem is clinically significant. The overly narrow focus on symptoms utilized by the biomedical approach has been criticized for contributing to the medicalization of normal shyness.⁵

Diagnostic interviews, such as the Structured Clinical Interview for DSM-IV Axis I Disorders²⁹ include sections on SAD that assess avoidance and impairment/distress associated with anxiety. Because these interviews may increase the time burden during an office visit, there are several general questions outside of a structured interview that you can ask, such as: "Has this anxiety interfered with your ability to initiate or maintain friendships? If so, how?" (Table 2). Persons with clinically significant social anxiety, rather than shyness, tend to report greater effects on their relationships

and on work or school performance, as well as greater distress about having that anxiety.

Treatment approaches based on distinctions

Exercise care in making the distinction between normal shyness and dysfunctional and impairing levels of anxiety characteristic of SAD, because persons who display normal shyness but who are overdiagnosed might feel stigmatized by a diagnostic label.⁵ Also, overpathologizing shyness takes what is a social problem out of context, and could promote treatment strategies that might not be helpful or effective.³⁰

Unnecessary diagnosis might lead to unnecessary treatment, such as prescribing an antidepressant or benzodiazepine. Avoiding such a situation is important, because of the side effects associated with medication and the potential for dependence and withdrawal effects with benzodiazepines.

Persons who exhibit normal shyness do not require medical treatment and, often, do not want it. However, some people may be interested in improving their ability to function in social interactions. Self-help approaches or brief psychotherapy (eg, cognitive-behavioral therapy [CBT]) should be the first step—and might be all that is necessary.

The opposite side of the problem.

Under-recognition of clinically significant social anxiety can lead to under-treatment, which is common even in patients with a SAD diagnosis.³¹ Treatment options include CBT, medication, and CBT combined with medication (*Table 3*):

- several studies have demonstrated the short- and long-term efficacy of CBT alone for SAD
- medication alone has been efficacious in the short-term, but less efficacious than CBT in the long-term
- combined treatment also has been shown to be more efficacious than CBT or medication alone in the short-term
- there is evidence to suggest that CBT alone is more efficacious in the long-term compared with combined treatment.^a

^aFor more information about treatment strategies, Dalrymple has published a review elsewhere.¹¹

Table 3

Options for treating SAD^a

Psychotherapy	Pharmacotherapy
Cognitive-behavior therapy (individual or group)	Selective serotonin reuptake inhibitors <ul style="list-style-type: none"> • Paroxetine • Sertraline • Fluoxetine • Fluvoxamine
Acceptance and commitment therapy	Serotonin-norepinephrine reuptake inhibitor: Venlafaxine
Interpersonal psychotherapy	Benzodiazepines <ul style="list-style-type: none"> • Clonazepam • Alprazolam
Short-term psychodynamic therapy	Monoamine oxidase inhibitor: Phenelzine

^aBased on empirical studies

Note: Medications with an FDA indication for SAD are in bold type

SAD: social anxiety disorder

CBT is recommended as an appropriate first-line option, especially for mild and moderate SAD; it is the preferred initial treatment option of the United Kingdom's National Institute for Health and Care Excellence (NICE). For more severe presentations (such as the presence of comorbidity) or when a patient did not respond to an adequate course of CBT, combined treatment might be an option—the goal being to taper the medication and continue CBT as a longer-term treatment. Research has shown that continuing CBT while discontinuing medication helps prevent relapse.^{32,33}

Appropriate pharmacotherapy options include selective serotonin reuptake inhibitors and serotonin-norepinephrine reuptake inhibitors.³⁴ Increasingly, benzodiazepines are considered less desirable; they are *not* recommended for routine use in SAD in the NICE guidelines. Those guidelines call for continuing pharmacotherapy for 6 months when a patient responds to treatment within 3 months, then discontinuing medication with the aid of CBT.

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Persons who exhibit normal shyness do not require medical treatment; however, some may want to improve their social functioning



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Appropriate pharmacotherapy options include SSRIs and SNRIs; benzodiazepines are considered less desirable

Related Resources

- National Institute of Health and Care Excellence. Social anxiety disorder: recognition, assessment, and treatment of social anxiety disorder. <http://guidance.nice.org.uk/cg159>.
- Hofmann SG, DiBartolo PM, eds. *Social anxiety: clinical, developmental, and social perspectives*, 2nd ed. London, United Kingdom: Academic Press; 2010.
- The Shyness Institute. www.shyness.com.

Drug Brand Names

Alprazolam • Xanax	Paroxetine • Paxil
Clonazepam • Klonopin	Phenelzine • Nardil
Fluoxetine • Prozac	Sertraline • Zoloft
Fluvoxamine • Luvox	Venlafaxine • Effexor

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Bottom Line

The severity of anxiety and associated impairment and distress are the main variables that differentiate normal shyness and clinically significant social anxiety. Taking care not to over-pathologize normal shyness and common social anxiety concerns or underdiagnose severe, impairing social anxiety disorder has important implications for treatment—and for whether a patient needs treatment at all.